**STATEMENT OF**
**MICHAEL HASH, DEPUTY ADMINISTRATOR**
**HEALTH CARE FINANCING ADMINISTRATION**
**MEDICARE+CHOICE AND CONSUMER INFORMATION**
**SENATE AGING COMMITTEE**
**MAY 6, 1998**

I am pleased to be here today to describe our plans to inform Medicare beneficiaries of their health plan options under the Balanced Budget Act of 1997 (BBA) and to assist them in making the right choice for their needs. Ensuring that beneficiaries are adequately informed of their options has been a major focus of this committee. You played a leadership role not only in defining the scope of the information campaign in the BBA but also in ensuring that it is adequately funded. Without adequate funding, beneficiaries will not have the tools they need to make the right choices.

We testified before your committee last year on this same issue. At that time, we described our various initiatives and I am pleased to report that we have made significant progress since then.

o We are in the process of gathering our first comprehensive picture of enrollee satisfaction through the Consumer Assessment of Health Plans Study (CAHPS) instrument. It is designed to provide a consumers-eye view of how health plans really work, and allow beneficiaries to make apples-to-apples comparisons between plans. Results will be available to Medicare beneficiaries by November 1998.

o We are finalizing plans for our first nationwide mailing of basic and comparative information on Medicare+Choice options, original fee-for-service Medicare, and private supplemental coverage "Medigap" policies available to beneficiaries.

o We are also finalizing plans for toll-free telephone service and local counseling services to assist beneficiaries in making informed choices.

o We will this fall release, via the Internet, comparative information on the Health Plan Employer Data and Information Set (HEDIS) measures for 1996 which were adapted for Medicare and include information on plan performance, such as mammography screening rates. Our new Internet site, Medicare.gov, will provide basic comparison information on Medicare plan options by zip-code through Medicare Compare.

As you know, the BBA expands health care options available to Medicare beneficiaries through the creation of the Medicare+Choice program. Under this program, Medicare beneficiaries will be able to choose to receive their Medicare benefits either through original Medicare, as the current Federally-administered fee-for-service program is now called, or from an array of Medicare+Choice private options such as Health Maintenance Organizations, Preferred Provider Organizations, Provider Sponsored Organizations, as well as Private Fee-for-Service Plans and Medical Savings Account Plans. These choices are designed to offer Medicare beneficiaries options similar to those available in the private sector to people with employment-based health insurance. Medicare+Choice also is designed to expand access to managed care options for Medicare beneficiaries in rural and other areas where these options have been lacking.

The BBA added new challenges to making sure Medicare beneficiaries have what they need to make informed choices.

o **Phased lock-in:** To date, beneficiaries could enter and drop out of managed care plans on a monthly

basis. Under BBA, beginning in 2002 beneficiaries will be locked into most Medicare+Choice options for six months. Starting in 2003, the lock-in period will be nine months. And beneficiaries enrolling in Medical Savings Accounts (MSAs) will be locked in for one year starting in 1999.

o **Changes in enrollee costs:** Some new options involve changes in enrollee costs. Medicare provides protections to limit beneficiaries out of pocket health care costs. However, under BBA, beneficiaries will be offered options which alter these protections. Private fee-for-service plans under BBA have no limits on premiums that can be charged to beneficiaries. Plans are free to negotiate their own payment rates, and providers can bill up to 15% beyond the plan's rates. With MSAs, beneficiaries must negotiate their own payment rates, and there are no limits on what providers can charge.

o **Benefits not standardized:** The BBA did not include provisions that would have made it easier to explain options to beneficiaries. It did not standardize commonly offered additional benefits, which would have made it easier for beneficiaries to compare Medicare+Choice and Medigap options. The BBA also did not include provisions to limit preexisting condition exclusions and expand open access for Medigap options for both disabled and elderly beneficiaries so that they can more freely move back into traditional fee-for-service Medicare. Without these provisions, it will be more of a challenge to help beneficiaries understand the consequences of some choices and whether specific options will meet their specific needs and desires.

We are doing our best to meet the challenges posed by the BBA within the limited discretion we have under the law, and I would like to summarize for you today our plans and the challenges that we face.

**The National Medicare Education Program**

While the Medicare+Choice program expands choice, as indicated above, the context for this choice will be significantly different than under Medicare's previous risk-contracting program. Besides weighing the value of additional benefits such as prescription drugs and low copayments that plans may offer, beneficiaries will also have to be aware of the potential for higher out-of-pocket expenses, variable supplemental benefits, and the implications of lock-in. The complexities added by the scope of options in the BBA are a concern because our research has shown us that, even before the BBA changes, many beneficiaries were confused about their basic Medicare benefits and, therefore, did not use the program to their full advantage.

Many beneficiaries do not understand the basics of the original Medicare fee-for-service program or their current HMO options, according to surveys by us and the HHS Inspector General. And beneficiaries with some understanding often have only superficial knowledge.

o For example, one third of beneficiaries reported knowing little or nothing about original Medicare benefits or out-of-pocket payment for services.

o Over 40 percent indicate that they know little or nothing about private supplemental policies.

o About one-third of beneficiaries do not understand that if they disagree with a payment or coverage decision, they have the right to appeal it.

o Perhaps most critically, 6 out of every 10 beneficiaries report knowing little or nothing about managed care.

In recent focus group testing of Medicare+Choice materials, we found that few beneficiaries have any

knowledge of the Balanced Budget Act or the Medicare+Choice initiative. When we have shown beneficiaries the options they will have under Medicare+Choice, many become overwhelmed by the number of choices, and even well educated beneficiaries have difficulty understanding them all.

Clearly, beneficiaries will need assistance to understand the implications of the expanded Medicare choices under the BBA and how to use the HCFA-developed information tools that will be available annually through the Medicare Handbook and via the World Wide Web. We also need to make sure beneficiaries understand that they can choose to do nothing and continue to receive care through original fee-for-service Medicare or their current managed care plan.

To respond to this need, HCFA is embarking on a National Medicare Education Program, the purpose of which is to ensure that our beneficiaries receive accurate, easily understandable information about their benefits, rights, and health plan options to assist them in becoming more active participants in their health care decisions.

We are establishing extensive partnerships in this effort. We have 23 partners on our coordinating committee. They includes the American Association of Health Plans, the American Association of Retired Persons, the federal Administration on Aging, the American Society on Aging, the AFL-CIO, the Consumer Coalition for Quality Health care, the Department of Defense TRICARE Marketing Office, Families USA Foundation, the Health Insurance Association of America, the Health Resources and Services Administration, the International Longevity Center, the Medicare Rights Center, the National Asian Pacific Center on Aging, the National Association of Area Agencies on Aging, the National Association of Community Health Centers, the National Association of State Units on Aging, the National Council of Senior Citizens, the National Institute on Aging, the National Institute on Diabetes and Digestive and Kidney Disease, the National Organization for Rare Disorders, the U.S. Office of Personnel Management Office of Insurance Programs, the Visiting Nurses Association of America, and Watson Wyatt Worldwide.

We have 15 organizations participating on task forces. They include the American Academy of Family Physicians, the American Hospital Association, the American Music Therapy Association, the American Nurses Association, the Employers' Managed Health Care Association, the General Services Administration Consumer Information center, the Georgetown Institute for Health Care Research and Policy, Hewitt Associates, Indian Health Services, the National Alliance for Caregiving, the National Osteoporosis Foundation, the People's Medical Society, Resource Connectors Ltd, the Spry Foundation, and Towers Perrin.

We have 28 organizations helping us as educational affiliates. They include the 60 Plus Association, Aging Services Inc., the Alliance for Aging Research, the American Academy of Family Physicians, the American Medical Rehabilitation Providers Association, the Association of Jewish Aging Services, the Ball State University Center for Gerontology, the Eastman Kodak Co., Iona Senior Services, the National Agricultural Library, the National Association of Insurance Commissioners, the National Association of People with AIDS, the National Association of Retired Federal Employees, the National Association of Social Workers, the National Coalition for the Homeless, the National Committee to Preserve Social Security and Medicare, the National Consumers League, the National Library of Medicine, the National Rural Health Association, the Office of Disease Prevention and Health Promotion, the Office of Minority Health Resource Center, the Partnership for Prevention, the Department of Labor President's Committee on Employment of People with Disabilities, the Substance Abuse and Mental Health Services Office of Managed Care, the Summit Health coalition, the United Auto Workers, the United Cerebral Palsy Institute on Disability and Managed Care, and the United Senior Health Cooperative.

We also intend to work closely with Health Insurance Advisory programs (formerly known as Health Insurance Information Counseling and Assistance programs), and hope to coordinate efforts with local agencies on aging.

Through this program, we want to educate Medicare beneficiaries so that they can make informed health plan decisions rather than making decisions based on inaccurate, misleading, or incomplete information.

The National Medicare Education Program will employ a number of strategies to educate beneficiaries regarding:

- Medicare program benefits
- health plan choices
- their rights, responsibilities, and protections
- health behaviors and health promotion

As part of this program, HCFA will provide access -- via the Web, a toll-free call center, and in print materials -- to general program information and specific comparative information about Medicare+Choice options. The information comparing plan options is crucial to empowering beneficiaries with the knowledge that will help them evaluate Medicare+Choice options along with the original Medicare program and make informed decisions based on their individual needs. Equally important is the need to make clear that HCFA's provision of local comparative data is intended neither to encourage or discourage beneficiaries from choosing one health care plan over another nor to favor a choice of a Medicare+Choice plan over original fee-for-service Medicare.

The National Medicare Education Program will use a phased educational approach moving from *awareness to understanding to use* of information by beneficiaries to make personal decisions about the best value health plan option for them.

In 1998 and 1999 we will begin the initial phases of the program during which we will: make beneficiaries aware that new health plan options are coming; prepare them for making an informed choice; and help them understand HCFA's role and mandate as it relates to Medicare. In all, we want to emphasize that the choice is theirs -- that is, they do not have to change if they are satisfied with the benefits and care that they are currently receiving.

During the next phase of the program (in 2000 and beyond), we want to help beneficiaries understand the importance of both making an informed choice and assessing the quality of services received under Medicare. We also want to emphasize to beneficiaries that they should make their choices based on their individual needs. For beneficiaries, their families, and others working on their behalf, we want to strive to assure that they: are aware of the resources and tools to use to help in the choice-making process; understand that Medicare cares about quality; and perceive that the Medicare program is a reliable and credible information broker about health care plans and coverage.

Through the program, we want to assure that our beneficiaries develop skills and acquire knowledge to make informed choices, including making use of comparative quality measures and assessing the appropriateness of available options given their individual medical needs. This activity is part of a larger effort to educate Medicare beneficiaries about ways to improve their health through healthy living and appropriate use of benefits.

The National Medicare Education Program is a five-year effort. We will be constantly learning from our efforts. A program assessment will be integrated into the design and implementation of the program.

The assessment will provide information to: 1) improve practices and procedures, 2) add or drop specific program strategies and techniques, and 3) replicate successful aspects of the program elsewhere. The focus of the program assessment will be whether the "right" actions are being taken in the "right" way, and whether the desired outcomes are being achieved.

**1998 Objectives**

HCFA's objectives for the National Medicare Education Program in 1998 include:

o Building alliances with other consumer centered organizations to work with HCFA in disseminating information and educating our beneficiaries and our other partners who work on beneficiaries' behalf. HCFA has invited a broad array of public and private sector organizations to join an Alliance Network to foster cooperation among these groups nationally and at the local level to enable Medicare beneficiaries to make informed health care decisions. These groups can choose to participate at three different increasingly active levels of involvement and leadership ranging from supporters in information dissemination to national leadership partners.

o Test-marketing alternative information broadcast approaches focusing on various Medicare managed care markets. We are formally testing information which will be presented in print and over the Internet with groups of beneficiaries to assess their understanding of the intent of the information and the usefulness of the style of the presentation.

o Developing a national community-based customer service strategy that leverages the existing community-based organization network and lays the foundation for future support from a broad base of public, private, and volunteer community-level support. While Medicare is a national program, beneficiaries interact with the health system locally. A sustainable community-based infrastructure is essential to support the counseling needs of beneficiaries. We are seeking approaches to develop and leverage existing networks of community-based organizations that can be used to assist beneficiaries. HCFA Regional Offices will take the lead in this effort beginning with developing local strategies for the special information campaign in 1998. We are also working with foundations to identify opportunities to fund development of innovative community programs.

o Educating and training principal information intermediaries, such as Health Insurance Advisory programs, advocacy groups, and community-based organizations. We are planning an intensive training program targeted to our contractors and our partners who will be actively involved in providing information and counseling to beneficiaries and those who work on their behalf. We will provide training regarding the program changes resulting from the Balanced Budget Act and the tools and resources that will be available to them in working with beneficiaries.

**Spending Plan for the National Medicare Education Program**

For the 1998 fiscal year, HCFA plans to spend about $114 million on the National Medicare Education Program. This includes $95 million collected in user fees, provided for in the BBA, and about $19 million from our program management and peer review organization (PRO) accounts, which will fund activities that would have been funded without the BBA but which will be folded into the comprehensive National Medicare Education Program. The lion's share of the money is devoted to the beneficiary handbook/plan comparisons and the 1-800 toll-free information line. Let me briefly outline our spending plan.

**Medicare Handbook/Medicare+Choice Comparisons** - In FY 1998, we estimate that the costs to

design, print and mail the combined Medicare Handbook/Medicare+Choice Plan Comparisons will be about $35 million, or just under $1.00 per beneficiary. An additional $10 million will be spent on related Medicare+Choice program printing needs, including the costs for printing and mailing the initial enrollment package to individuals who will soon be eligible for Medicare. Only one handbook will be mailed per household. The per person cost for the handbook is higher than in previous years because the health plan comparative information is being provided. We are currently estimating that there will be over 500 different versions of the plan comparison section of the handbook. Each version will be tailored to the options available in the market in which the beneficiary resides. The 1999 version of the book will be mailed to beneficiaries in the fall so it can be used during the November open enrollment period. The information included in plan comparisons will be expanded over time to include HEDIS performance measures, enrollee satisfaction results and disenrollment rate information.

**1-800-MEDICARE -** We estimate that the cost for the 1-800-MEDICARE toll-free call center will be just under $45 million in FY 1998. Needless to say, we are not as confident of this estimate because of the tremendous uncertainty regarding how many beneficiaries will utilize this service and how long the average call will last. Callers to the service will first reach an automated response unit that could be either touch-tone or voice activated. Spanish language and hearing impaired service will be provided. This service will be available 24 hours a day, 7 days a week and will allow callers to order Medicare publications, request a disenrollment form or hear recorded answers to frequently asked Medicare+Choice questions. Callers also will be able to talk to customer service representatives from 8:00 a.m. through 4:30 p.m. local time, Monday through Friday, about more complex questions and to obtain comparative information about local health plan options. Once the service is operational nationwide, we estimate that over 2,000 service reps will be needed during peak call times.

**Community Support/Information Infrastructure** - The remaining $24 million will fund a host of other activities, including (1) the Internet site, which will provide comparative information to beneficiaries and those who counsel with them, (2) the Health Insurance Advisory Program activities, (3) surveys of enrollee satisfaction, (4) a national publicity campaign which will feature health fairs, (5) development of information materials to be used by beneficiary counselors, and (6) evaluations and other projects to monitor and improve how we communicate this important information to our beneficiaries.

**FY 1999 Request -** For fiscal year 1999, we are estimating that we need about $173 million --the full amount of user fees authorized in the BBA ($150 million) and $23 million from our program administration and PRO accounts, which will fund activities that would have been funded without the BBA but which will be folded into the comprehensive National Medicare Education Program. Most of the increase is devoted to a much larger projected cost for the 1-800-MEDICARE toll-free line. In both FY 1998 and FY 1999, some of the funds are needed for start-up costs, such as training and management information systems. We anticipate that in FY 2000 when start-up activities are completed, the line item for this activity will be less than it is in FY 1999.

Specifically, for FY 1999 we are again projecting about $45 million for the handbook and other printing needs. We estimate $80 million for the toll-free service; about $33 million for HIA, beneficiary satisfaction surveys, a national publicity campaign featuring health fairs, the Internet site, and evaluation of the consumer information activities; and reserving about $15 million in a contingency fund, given the uncertainty of the demand for toll-free call center services.

We appreciate the support of this Committee for the appropriation of the full amount authorized for the 1999 user fees. We should point out that since $23 million in funding is coming from other sources, it is imperative that both HCFA's full FY 1999 appropriation request and our request for authority for user fees for other parts of the program be approved. We also want to call to your attention to the fact that the

BBA authorizes $100 million in user fees for consumer education and information activities in fiscal years 2000 and beyond. Given the current uncertainty over beneficiary demand for Medicare+Choice options, we may need to revisit the adequacy of this funding level once we have a better understanding of the type of information beneficiaries find useful.

**CONCLUSION**

While we support broader choices for Medicare beneficiaries, implementing the Medicare+Choice program presents HCFA with many new challenges. Key among them is to ensure that Medicare beneficiaries receive accurate, easily understandable information about their benefits, rights, and health plan options so that they can make informed health plan decisions. We are committed to giving beneficiaries accessible information so that they can avoid making decisions based on inaccurate, misleading, or incomplete information. This is an extremely important task, and we know that we cannot succeed without adequate resources. We trust that this Committee will continue to play a leadership role in trying to ensure that beneficiaries have the tools that they need to make informed choices.